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| S0000 | | | | |
| | This visit was for a State hospital licensure survey.<br><br>Dates: 9/13/2011 through 9/15/2011<br><br>Facility Number: 004171<br><br>Surveyors:<br>Albert Daeger, CFM, SFPIO<br>Medical Surveyor<br><br>Sandy Nolfi, RN<br>PH Nurse Surveyor<br><br>QA: claughlin 09/23/11 | S0000 | Thank you very much for your visit. Sandy Nolfi and Albert Haeger were very professional and provided much insite into the State requirements. They were thorough and exceptionally helpful, with suggestions for process and functional improvement. We have already implemented changes based on their findings and suggestions, and anticipate continuous improvement.Very Sincerely,Jennifer Balascio, MSN, Director of Quality | |
| S0322 | 410 IAC 15-1.4-1(c)(6)(H)<br><br>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:<br>(6) Require that the chief executive officer develops policies and programs for the following:<br><br>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at least triennially.<br>Based on document review and staff interview, the facility failed to ensure the policy on Salad Bars, Quick Serve and Deli Self-Service Items was updated | S0322 | Pete Kachur, Mgr Food and Nutrition, is responsible for this corrective action. The policy is in draft and awaiting final approval from the SDOH. On 9/21/11 the | 10/14/2011 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | meeting the current Indiana State Department of Health Retail Food Sanitation Requirements.<br><br>Findings included:of<br><br>1. Retail Food Establishment Sanitation Requirements Title 410 IAC 7-24 was effective November 13, 2004. Section 193 of 410 IAC 7-24 references Time as a Public Health Control. This code repealed Title 410 IAC 7-20.<br><br>2. Nutrition and Dietetic's policy referencing Salad Bars, Quick Serve and Deli Self-Service Items effective Date 8/15/2011 section III states, "Section 175 of the Indiana Department of Health's Retail Establishment states that time can be used as a Public Health Control." Section IV reference Indiana State Department of Health Retail Food Establishment Sanitation Requirements Title 410 IAC 7-20 (April 29, 2000)."<br><br>3. At 2:00 PM on 9/13/2011, staff member A10 indicated he/she did not know the State retail food code was updated. The staff member indicated he/she did not have a copy of the current food code to reference.<br><br>3. | | first draft was sent to ISDH for approval. On 10/3/11 the first draft was sent back for revision by ISDH (Albert D.) and the second draft sent back on 10/3/11 for approval. Item 2-3, this policy does incorporate updated references.<br>The implementation of this policy will resolve the deficiencies. | |

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| S0554 | 410 IAC 15-1.5-2(a)<br><br>(a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors.<br>Based on policy review, observation and interview, the facility failed to ensure the patient beds/carts were maintained in a clean, sanitary manner in the preadmission surgical area, PACU (post-anesthesia care unit), labor and delivery triage area, the emergency department and the ICU (Intensive Care Unit) and failed to ensure staff was able to sanitize and/or wash their hands before leaving the Body Holding Room.<br><br>Findings included:<br><br>1. Facility policy titled "Standard Precautions", effective date 12/15/2009, stated on page 5, ..."Environmental Control- [Facility name] cleaning and disinfection procedures for the routine care, cleaning, and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces are to be performed by Environmental Services Associates daily in order to reduce the biological burden | S0554 | Shane Fulford, Manager EVS is responsible for correction of this deficiency. Prior to ISDH visit, EVS did not manage the cleaning of the beds; rather, it was the responsibility of the techs on that unit. Since inspection the EVS dept has started cleaning all beds in the unit daily. Items 2-6: The following addendum has been added to our policy, and monthly audits are to be performed to ensure compliance. End of Day Terminal Cart Cleaning Process in POC/PACU, ED, and Cath Lab1) After last patient of day or on third shift, clinical staff strips linen from cart with rails down.2) Rails down are a cue that carts are soiled and need to be terminally cleaned by EVS staff.3) EVS cleans cart starting with mattress (must be cleaned both sides) with hospital approved detergent/disinfectant.4) Cart mattress platform is cleaned with detergent/disinfectant.5) Base of cart is dry dusted and then damp wiped with hospital detergent/disinfectant.6) Finally, rails are cleaned with hospital | 10/07/2011 |

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| | within [Facility name] premises."<br><br>2. During the tour of the surgical areas, beginning at 10:10 AM on 09/14/11 and accompanied by staff members A4, A5, and A35, the following observations were made:<br><br>A. A heavy layer of dust on the bottoms of the patient beds/carts in the preadmission rooms.<br>B. A heavy layer of dust on the bottoms of the patient beds/carts in the PACU.<br><br>3. During the tour of the labor and delivery area, beginning at 11:50 AM on 09/14/11 and accompanied by staff members A4, A5, and A23, a heavy layer of dust was observed on the bottoms of the patient beds/carts in the triage area.<br><br>4. During the tour of the emergency department, beginning at 9:10 AM on 09/15/11 and accompanied by staff members A4, A5, and A26, a heavy layer of dust was observed on the bottoms of the patient beds/cart in the ambulance entry area.<br><br>5. During the tour of the ICU, beginning at 10:30 AM on 09/15/11 and accompanied by staff members A4, A5, A30, and A31, a heavy layer of dust was observed on the bottoms of the patient | | detergent/disinfectant and left in upright position to dry.7) Upright rails are cue to clinical staff that carts have been cleaned and ready to be dressed with a sheet for patient use.Cart cleaning process for OB triage1) OB triage clinical staff will strip cart of linen once patient leaves room.2) EVS will clean cart starting with mattress (must be cleaned both sides) with hospital approved detergent/disinfectant.3) Cart mattress platform is cleaned with detergent/disinfectant.4) Base of cart is dry dusted and then damped wiped with hospital detergent/disinfectant.5) Finally, rails are cleaned with hospital detergent/disinfectant and left in upright position to dry.6) Upright rails are cue to OB triage clinical staff to dress cart with sheet for patient use.Bed cleaning process for Clinical Units1) Clinical/support staff will strip linen from bed once patient is discharged from room.2) EVS will clean bed beginning with mattress (must be cleaned both sides) with hospital approved detergent/disinfectant.3) Bed mattress platform, head and foot boards are then cleaned with hospital detergent/disinfectant4) Base of bed is dry dusted and then wiped with hospital detergent/disinfectant.5) Finally, bed rails and call light attachment are cleaned with detergent/disinfectant and left in upright position to dry.6) Upright | |

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| | beds/carts in the rooms.<br><br>6. At 10:20 AM on 09/14/11, staff member A35 indicated the nursing support staff clean the beds/carts between patients in the preadmission and PACU areas.<br><br>7. At 1:30 PM on 9/14/2011, the receiving dock was toured. On the receiving dock was a secured room that contained a portable body holding refrigerator. The refrigerator doors were open to inspect for cleanliness. After the doors were closed, it was observed that the room did not have any hand washing sink or wall mounted sanitizing station. Outside the room on the dock was a hand washing sink; however, the sink was obstructed by a skid filled with boxes of merchandise which made it inaccessible to wash hands. | | rails are cue to clinical/support staff that bed is ready to be dressed with linen.Item 7: A Purell hand sanitizer has been mounted directly outside and adjacent to the morgue door to provide a sanitizing station for the morgue. | |

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| S0606 | 410 IAC 15-1.5-2(f)(3)(D)(viii)<br><br>(f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows:<br>(3) The infection control committee responsibilities shall include, but not be limited to, the following:<br>(D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following:<br><br>(viii) An employee health program to determine the communicable disease history of new personnel as required by state and federal agencies. | | | |
| | Based on policy review, staff record review, and interview, the facility failed to include the Varicella immune status of employees in its health assessment program.<br><br>Findings included:<br><br>1. The facility policy titled, "Pre-Placement Health Assessment", last revised 05/23/11, stated on page 3, ..."2. Rubeola (Measles)/ Mumps/ Rubella (German Measles) a. At the time of pre-placement health assessment, the measles/ Mumps/ Rubella immune status of all candidates must be determined, per requirement of the Indiana State Department of Health." The policy failed | S0606 | Donna Bopp, Infection Control and Stephanie Dahlke, AOHS, are responsible for correction of this deficiency. Varicella pre-hire survailence was not a routine practice for IUHealth North Hospital. Upon review of the findings of the ISDH, we have implemented a Varicella Policy on 10/3/2011 which states:I. PURPOSEVaricella (chickenpox) is an extremely contagious viral illness, which can cause severe infections in immune compromised hosts. This document provides facts and guidelines with respect to the risk of transmission of Varicella, to guide actions to limit the spread of Varicella.II. SCOPEThis policy applies to all units, services, and individuals, including but not limited to staff, physicians, | 10/03/2011 |

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|---|---|---|---|---|
| | to address the Varicella immune status.<br><br>2. Review of employee medical files with staff members A4, A7, A15, A33, and A34 indicated no Varicella information for employees PP1 and PP20 and a self-attested history of the Chicken Pox disease for employees PP2, 3, 5, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19 and N1, 2, 3, 4, 6, 7, 8, 9, 10, 11, and 12.<br><br>3. At 1:40 PM on 09/14/11, the employee health nurse, staff member A21, indicated the facility had not been requiring documentation of Varicella immunity, proof of the disease, or a titer. | | licensed independent practitioners, volunteers, students, contractors, and visitors.III. DEFINITIONS Varicella Zoster Virus (VZV) – the virus that causes chickenpox Varicella Virus – the virus that fits chicken pox Herpes Zoster – the cause of Shingles in a person who has been previously infected by the VZV. Shingles – a neuralgic/painful rash that appears in individuals who have previously had chickenpox. IV. GENERAL INFORMATIONThe application of these guidelines to specific situations (e.g., visitation, outpatient surgery, exposure in the ambulatory setting and inpatient exposures) is quite variable and the Infection Control Department is available to help with these decisions. When clinical chickenpox is known or suspected, Airborne Precautions with negative air flow room and Contact Precautions must both be used. Varicella (chickenpox) is caused by the Varicella zoster virus (VZV). This virus is also the cause of herpes zoster (shingles). The following are some facts regarding the transmission of chickenpox.• Chickenpox is transmitted primarily by the respiratory route and is highly contagious. Transmission occurs primarily by direct contact with patients with varicella or zoster and occasionally occurs by airborne | |

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|---|---|---|---|---|
| | | | spread from respiratory secretions and rarely, from zoster lesions. Nosocomial infections occur in hospital settings.• Shingles is not contagious to those who have had chickenpox. • Shingles may be contagious to someone who has not had chickenpox, but that person must come in direct contact with drainage from the rash of the person with Shingles. The person would actually develop chickenpox, not Shingles.• The Varicella vaccine is not fully protective. Therefore, an immunized individual who develops a suspicious rash should be placed in appropriate isolation until the nature of the rash is determined. Patients are most contagious from 1-2 days before and shortly after the onset of the rash. They may remain contagious for as long as 5 days after the onset of lesions. • The incubation period is usually 8-22 days after contact. Patients who receive Varicella zoster immunoglobulin (VZIG) may develop lesions up to 28 days following exposure.• The vaccine for Shingles, also known as Zostavax is given to adults age 60 and older. It has not been known to cause transmission of Chickenpox. If the person who receives the vaccine develops a rash, the rash should be covered until it disappears.V. PROCEDURE(s) Patients and visitors immunized against | |

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|---|---|---|---|---|
| | | | Varicella (chickenpox) should be evaluated for potential transmission of chickenpox according to the following information guidelines:• Any individual, who develops a suspicious rash, whether or not it appears compatible with Varicella, should be placed in isolation until it is evaluated. This includes all patients whether or not they have received the Varicella vaccine.• All patients exposed to Varicella will be isolated in Airborne Precautions with negative air flow room if they have no history of disease or have a negative titer.• Patients with Varicella should be placed in Airborne Precautions with negative air flow room. All caretakers must wear gowns, surgical masks (not N95 respirators) and gloves when entering the room until isolation is discontinued.• Facilities should be notified by patient care staff before a patient requiring negative air pressure is admitted into the designated negative pressure room.• Patients who receive the immunization for Varicella may develop Varicella within the first week to two weeks of receiving their immunizations due to exposure to wild strain of chickenpox about which they were unaware. These patients should be placed in Airborne Precautions with negative air flow room and Contact Precautions.• Patients and/or visitors who have | |

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| | | | received the immunization for Varicella within the prior 30 days are at some, albeit small, risk of transmitting the vaccine virus. Transmission has only been associated with individuals who have developed lesions. This is an infrequent occurrence. • Patients immunized against Varicella (chickenpox) who develop lesions are to be placed in Airborne Precautions and Contact Precautions until the lesions are dry and crusted over.• Individuals less than 13 years of age are considered immune to Varicella (chickenpox) AFTER the 30th day following vaccination. Individuals who receive the vaccine past 13 years of age are considered immune 30 days after the second vaccine dose.• Inpatients that are exposed to chickenpox will be considered immune only if they have a history of disease or a positive Varicella titer. Individuals who wish to visit a unit in which visitation is restricted to individuals who are immune to Varicella may do so if 1) they are free of rashes; 2) have previously had Varicella; or, 3) have received the Varicella vaccine at least 30 days earlier if a single dose (or following the second dose if administered when older than 13 years of age) and they have not been exposed to Varicella within the prior 22 days.VI. Evidenced Based/ReferenceVaccines and Preventable Diseases: Varicella | |

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| | | | (Chickenpox) Vaccination, 2008, Centers for Disease Control and PreventionVaccines and Preventable Diseases: Shingles (Herpes Zoster) Vaccination, 2008, Centers for Disease Control and Prevention Regarding item 2: A risk mitigation and cost analysis were performed, and it would be a significant financial burden to test and immunize existing staff, particularly in light of 2010 ISDH report of 7.21 cases/100,000 population, with only 12 cases hospitalized in Indiana in 2009. The documents mentioned above are attached. | |
| S0932 | 410 IAC 15-1.5-6 (b)(4)<br><br>(b) The nursing service shall have the following:<br><br>(4) The nursing staff shall develop and utilize an ongoing individualized plan of care based on standards of care for each patient. | | | |
| | Based on medical record review and interview, the facility failed to ensure 4 of 12 closed patient records (P1, P3, P5, and P14) and 2 of 5 inpatient records (P17 and P19) had individualized care plans.<br><br>Findings included:<br><br>1. The record for patient #P1, who was admitted for bilateral knee replacements on 08/23/11, indicated a history of increased bleeding after surgeries. The | S0932 | Janis Watts, Clinical IT, Damita Williams, CNO, and all nursing leadership are responsible for correction of this deficiency. In January, 2011 Indiana University Health hospitals jointly kicked off a system-wide project to redesign and consolidate its documentation systems. IU Health North Hospital is an active participant in this process. Over a 9 month period of time, project participants developed a philosophy for documentation intended to decrease redundancy | 10/07/2011 |

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| | plan of care failed to address that problem.<br><br>2. The records for newborn male infants, #P3 born on 06/16/11 and #P5 born on 08/21/11, failed to address the circumcision procedure, that both infants experienced, in their plans of care.<br><br>3. The record for patient #P14, who was admitted due to mental status changes, failed to address that problem in the plan of care.<br><br>4. The record for patient #P17, an infant male who was born on 09/12/11 and experienced a circumcision, failed to address that problem in the plan of care.<br><br>5. The record for patient #P19, who was admitted on 09/13/11 with a complaint of fever for 4 days, indicated a care plan of fall prevention and medication error prevention.<br><br>6. At 9:55 AM on 09/15/11, staff member #A29 confirmed the care plan for patient #P19 was not individualized.<br><br>7. At 1:00 PM on 09/15/11, staff member #A18 confirmed the care plan findings on the closed records. | | and variation, improve communication, and identify pertinent information vital to care of the patient in the acute care environment. A portion of this work focused on a paradigm shift in our thinking about patient care plans. We recognized that the current electronic record functionality limited the nurse's ability to fully individualize a care plan to reflect patient specific problems and needed interventions. The existing tool also did not serve us well in guiding the nurse to implement evidence-based interventions appropriate for his/her patient. As the EMR has continued to evolve, new functionality was introduced 6 days prior to the ISDH visit which allows us to provide a means to supporting this need. As a result of intentional focus during the clinical documentation redesign project, 5 general care plan templates based upon nurse sensitive indicators for skin integrity, falls, patient safety, pain management, and mobility were developed in an ongoing effort to standardize minimum patient care requirements. Each plan is built to include suggestions to guide the nurse in selecting appropriate interdisciplinary goals and interventions specific to her patient. A plan template is suggested to the nurse based upon information that is gathered through the admission process. The nurse utilizes her | |

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|---|---|---|---|
| | 150161 | A. BUILDING 00<br>B. WING | 09/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| INDIANA UNIVERSITY HEALTH NORTH HOSPITAL | 11700 N MERIDIAN ST<br>CARMEL, IN46032 |

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|---|---|---|---|---|
| | | | professional judgment to determine if the plan is pertinent to the current patient needs. Additionally, the new format allows the nurse to enter patient specific goals and interventions on an ad hoc basis. The ongoing intent is to develop a critical mass of evidence- based, disease/condition, and nurse sensitive indicator driven plans of care over the next 6 months. The nurse is expected to address active problems that are pertinent to the patient's current condition and will direct impact to the patient outcome during the episode of care. While it is critical to capture and provide interdisciplinary awareness of pertinent historical data, they are not expected to address all historical problems that the patient reports if they are not actively affecting the current admission. Nurses are expected to review the care plans twice daily; once at the beginning of the shift to determine priority goals for the day, and at the end of shift to validate that the patient has or has not met the therapy goals. A copy of the Documentation Philosophy statement follows below. This Philosophy drives the decisions that are made about what to include in the patient record. The Philosophy of Documentation of Indiana University Health is a foundational element which establishes guiding principles to accurately | |

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|---|---|---|---|---|
| | | | and effectively reflect the patient's health care journey via the interdisciplinary clinical record. The record is a means to facilitate the flow of communication and intervention between the patient, their family and the health care team. The record supports a view of the patient that is meaningful. It defines the plan of care, reflects the intensity of the care needed, and details the patient's progress toward the achievement of goals and the realization of an effective discharge.The documentation model promotes standardization, adherence to consistent work flow processes and clinical guidelines while defining acceptable variances. In this fashion, it achieves visibility of the clinician's intervention, determines the effectiveness on the outcome of the patient and facilitates the clinician's progress from novice to expert through reflection of competency. Documentation is structured in such a way that it can guide the clinician through the required elements and support critical thinking with evidence-based criteria as decisions are made. The workflows are efficient and streamlined where data capture is judicious (avoiding duplication and redundancy), pertinent and positive to the condition and outcome of the patient. The record is populated with coded content that drives identification of problems, assessments and | |

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|---|---|---|---|---|
| | | | care planning. It supports data collection of the care provided and the outcomes achieved in as close to real-time as possible. Finally, information is retrievable, human-readable, measurable, comparable across settings and ultimately contributes to the knowledge of the clinician and the patient. The minimum standards for care planning are outlined in the new documentation policy as follows:1. Plan of CareRegardless of documentation method, a plan of care must be initiated within 8 hours of admission. a. Accept or reject any auto-generated plans based on nursing assessment. b. Initiate any plan not auto-generated that would be appropriate for the patient based on the nursing assessment of primary problems. c. For all accepted plans, the nurse will define the plan by selecting appropriate goals, interventions, and orders. d. Identify a minimum of one daily goal per problem.e. Include restraints/seclusion if intervention is implemented.f. Include 'Prevention of Injury' as part of each patient's plan of care. 2. Plan of Carea. During each shift, the nurse will review the current care plans initiated and revise them as needed based on the patient's situation.b. If new problems are identified, initiate any relevant care plans selecting appropriate goals, interventions, and orders.c. Document any nursing interventions | |

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|---|---|---|---|---|
| | | | completed.d. The nurse will mark all goals as met or not met. For goals that are not met, a reason for the variance should be documented. e. Include restraints/seclusion if intervention is implemented.As the implementation of this tool was a new process, an auditing process to determine effectiveness of the change has been developed. Over the next 90 days, the nursing units will audit a minimum of 30 charts each utilizing the attached tool. Audit results will be shared in departmental staff meetings. The Clinical Informatics nurses are continuing to round on staff 2-3 times/week to provide individual education on how to properly utilize the tools. The new policy will be implemented within the next 30 days and will be pushed to all staff as a required read. Care Plan Audit ToolUnit:_____ Today's Date _____ FIN:_____ _ Audit Date: _____ Shift Timeframe Being Audited: MRN:_____ _ Room #:_____ Auditor:_____ __ Comments1. What plan(s) of care are initiated on the patient? 2. IDPOC: Have the plan(s) goals been reviewed once per shift Y N 3. IDPOC: If goals are not met, is there a reason listed and an action documented? Y N 4. IDPOC: Has the Discharge plan been initiated? Y | |

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|---|---|---|---|---|
| | | | N 5. IDPOC: Have any other problems been identified? Y N 6. IDPOC: If problems have been identified, is there at least one goal and one intervention listed? Y N N/A 7. IDPOC: If pt. has restraints, is it marked on the plan? Y N N/A 8. IDPOC: If pt. is in isolation, is it documented on the plan? Y N N/A 9. PPOC: Have the plan(s) goals been reviewed once per shift Y N 10. PPOC: Are there any suggested plans that have not been addressed? Y N 11.PPOC: Are the plans initiated and not left in a planned state? Y N 13.PPOC: Is there only one plan initiated for a problem? Y N 14.PPOC: If Progressive Mobility plan is initiated, is there one level goal with interventions initiated? Y N N/A 15.PPOC: If goals are not met, is there a reason listed and an action documented? Y N 16. Have any patient specific goals or interventions been identified? Y N N/A Specific to the patients cited in the ISDH report: 1, 3, 4, 5, 6. Care plans will be individualized as outlined in the above information to address disease/condition specific and nurse sensitive indicators.2. Circumcision is routinely addressed in the Routine Newborn Order Set and Newborn Care Guidelines. The procedure, pain management and follow-up assessment and teaching are documented in OBTV. However, the circumcision procedure has | |

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|---|---|---|---|
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|---|---|---|---|---|
| | | | not been routinely documented in the nursing care plan. To address the issue the following steps are being taken:A reminder email has been sent to all PP nurses explaining that as a standard of practice, circumcision must be included on the care plan of any male infant undergoing the procedure (has already been built as an option in OBTV). This practice will be reinforced at the PP Blitz in November. A random audit of 30 newborn male charts will be performed in October, November and December, 2011, to assess compliance. Beginning in 2012, documentation of circumcision on the care plan will be added to our routine Newborn Chart Audits. | |
| S1118 | 410 IAC 15-1.5-8 (b)(2)<br><br>(b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows:<br><br>(2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees.<br>Based on observation, document review and interview, the facility failed to ensure there was no condition maintained which may result in a hazard to patients, public, or staff for the Maintenance Shop and Floor Equipment Room and failed to | S1118 | Mark McLean, Director Operations, is responsible for the correction of these deficiencies.S1118 – Finding 1/2: On October 6, 2011, eye wash station was installed in Floor Equipment Room. Evidence provided by photo attached.S1118 | 10/07/2011 |

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|---|---|---|---|---|
| | ensure the malignant hyperthermia cart was readily available in the event of an emergency in the obstetrical surgical area.<br><br>Findings included:<br><br>1. At 9:45 AM on 9/14/2011, the Floor Equipment Room was inspected. The room contained 4 of 8 floor scrubbers were observed having their batteries charged. Charging of the floor scrubbers exposes their batteries which are not acid free batteries. The room contained no eye wash station. This presented a hazardous condition if sulfuric acid from the floor scrubber batteries would splash into a staff member's eyes.<br><br>2. At 9:50 AM on 9/14/2011, staff member A16 indicated he/she agreed that there should be an eye wash station located in the room for safety precautions of the staff who would operate the floor scrubbers.<br><br>3. At 10:30 AM on 9/14/2011, the Maintenance Shop was toured. The room had 2 electrical bench grinding wheels. One of the bench grinding wheels had no safety guards to protect the operator from sparks and/or foreign objects that are discharged from the grinding operation. | | – Finding 3: Eye shields for the bench grinder were ordered 9/15/2011. Evidence provided by the attached purchase requisition. Eye guards will be installed by end of business 10/7/2011. Photographic evidence will be provided at that time. Photos uploaded with other documents.4. Diane Hesson, Manager of L&D, is responsible for correction of this deficiency. Diane had the locking mechanism removed from the cart the same morning it was discovered.Follow-up discussion with OR (Diana McDowell) revealed that their cart is secured with break away ties and checked daily (just like a code cart). According to Diana, an OR where she previously worked was cited by the ISDH because they did not have their cart secured…concern being anyone could take something off the cart and it would not be available in a true emergency. Since this cart is maintained by Pharmacy, Diane is working with Jane to ensure that the main OR and OB OR's carts are identical. | |

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|---|---|---|---|
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|---|---|
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| | 4. At 10:45 AM on 09/15/11, a request was made to the OB manager, staff member A23, to inspect the malignant hyperthermia cart for the surgical area. Staff member A23 wheeled the cart out to the hallway, but was unable to open it. The key entry was taped over and staff member A23 indicated the cart was supposed to be unlocked at all times. He/she indicated he/she did not know how this happened, but indicated it had happened yesterday also. It took eight minutes for another staff member to come out and manipulate the knob and buttons to get the cart unlocked.<br><br>5. At 11:00 AM on 09/15/11, staff members A4, A5 and A23 confirmed that a delay due to the cart being inadvertently locked could be a potential problem in the event of an emergency, especially if it occurred at a time of decreased staffing such as in the middle of the night. | | | |

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|---|---|---|---|
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|---|---|---|---|---|
| S1186 | 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E)(i)(ii)(iii)(iv)(v)<br><br>(f) The safety management program shall include, but not be limited to, the following:<br>(3) The safety program that includes, but is not limited to, the following:<br><br>(A) Patient safety.<br>(B) Health care worker safety.<br>(C) Public and visitor safety.<br>(D) Hazardous materials and wastes management in accordance with federal and state rules.<br>(E) A written fire control plan that contains provisions for the following:<br>(i) Prompt reporting of fires.<br>(ii) Extinguishing of fires.<br>(ii) Protection of patients, personnel, and guests.<br>(iv) Evacuation.<br>(v) Cooperation with firefighting authorities.<br><br>Based on document review, the facility failed to ensure all staff participated in the fire drills that were conducted as per the facility's Fire Safety Management Plan.<br><br>Findings included:<br><br>1. Fire Safety Management Plan EC.02.03.01 states, "IU Health North facilities are maintained in compliance with the Life Safety Code (NFPA 101, 2000 edition). Compliance is maintained by ongoing inspection and prevention maintenance of key elements." The Fire | S1186 | Mark McLean, Director Operations, is responsible for correcting these deficiencies.S1186 – Finding 1/ 2: Dashboard for tracking evidence of fire drills has been changed to match policy – ensuring continuity between policy, action and documentation.S1186 – Finding 3: IUHN will take responsibility for conducting fire drills at the offsite locations (rather than rely in building ownership). 4th quarter drills will be conducted during October to ensure match with annual requirement. Thsse fire drills were completed by | 10/07/2011 |

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|---|---|---|---|
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|---|---|
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| | Safety Management Plan for Fire Drills states, "Fire Drills are conducted in the hospital once per shift per quarter in each building defined as a health care occupancy by the Life Safety Code. All staff who work in the buildings where patients are housed or treated are required to participate in the drills to the extent the fire plan describes. This includes all hospital staff, and all IU Health North Hospital staff in buildings where space is shared with others."<br><br>2. The facility maintains a dashboard with all departments of the hospital on it that notes all the fire drills that are required for each of the departments as defined in the Fire Safety Management Plan. Besides the dashboard, the facility maintain copies of the actual fire drills that were conducted which matched up with the dashboard documentation except for the Power House fire drills. The Power House staff members provided one fire drill they conducted. The fire drill documentation was reviewed for the first 2 complete quarters of 2011. Staff members of four departments did not participate in either quarter's fire drills: PDC, NICU, Emergency, and Cath Lab. Staff members of the following 7 departments missed at least one shift's fire drills in 1st or 2nd quarter of 2011: Central Supply, Material Handling, Lab, | | October 7, 2011. Code Red Response/Evaluation forms will be provided as evidence. | |

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| | Pharmacy, MRI, ENDO, and Power House.<br><br>3. The hospital has 3 offsite locations: IUH North Radiology at Springmill, IUH North Hospital Sleep Disorder Center, and IUH North Outpatient Rehab at IU Sports Performance. Each location was only to conduct 1 fire drill per quarter because the units only are open for 1 shift. The facility did not provide any documentation of fire drills for 2011 for IUH North Radiology at Springmill and IUH North Outpatient Rehab at IU Sports Performance. However, the facility provided the second quarter fire drill for IUH North Hospital Sleep Disorder Center that was conducted by the City of Carmel. However, the fire drill conducted by the City of Carmel did not note who participated in the fire drill but noted there were 15 personnel that did not evacuate. The building houses more tenants than just the IUH North Hospital Sleep Disorder Center. The documentation did not note if the staff of the sleep disorder center participated in the fire drill. | | | |